STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	635 OAKHILL AVENUE PLYMOUTH, IN46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 13, 14, 15, 16, and 17, 2011 Facility number: 000041 Provider number: 155102 AIM number: 1002754000 Survey team: Vicki Manuwal RN, TC Sandra Haws RN Toni Krakowski RN Census bed type: 8 SNF 90 SNF/NF 2 Residential 100 Total Census payor type: 10 Medicare 73 Medicaid 14 Private 3 Other 100 Total Sample: 20 Supplemental sample: 3 These deficiencies also reflect state	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 6/22/11 Cathy Emswiller RN			
F0151 SS=E	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. Based on record review and interviews, the facility failed to ensure residents rights were respected by staff regarding resident refusal of Ted hose removal, a resident's choice to sleep in, and a resident having the choice of which under garment to be worn for 1 of 1 resident in a sample of 20 and for 3 of 3 residents in a supplemental sample of 3. Residents: # 29, # 104, # 27 and # 25 Findings include: 1. Resident # 104's closed record was reviewed on 6/17/11 at 9:30 a.m. The Resident's record indicated diagnoses of, but not limited to; history of falls,	F0151	**F151 Right to Exercise Rights – Free of Reprisal** It is the policy of Miller's Merry Manor – Plymouth that each resident has the right to be free form verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This deficiency has the potential to affect all residents on the unit where RN #1 was working. Resident #104 is discharged from the facility. Residents #29, #27, and #25 were interviewed on 6/16/2011 and felt confident in remaining in the facility. They were all assured that their individual rights will be respected. On 6/15/11, after being informed of the findings during resident council the Administrator, DON, and Social Service Director conducted	07/17/2011

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	Alzheimer's disease, and inability to ambulate. The Resident's record indicated she was admitted on 9/23/10. Review of the Resident's 5 day MDS (Minimum Data Set) assessment dated 10/1/10 indicated "cognition; modified independence- some difficulty in new situations only. Moods were present but easily altered." She needed extensive assistance with transfers, and dressing. A physician's order dated 10/4/10 indicated "Knee high Ted (thrombo embolic deterrent) hose on in a.m. off at p.m." Review of an incident reported dated 10/31/10 indicated the following; "The Director of Nursing was called and notified that during the midnight shift, a staff person was overheard speaking loudly to a resident and then removed her Ted hose despite her stating she wished to continue to wear them." The facility's investigation regarding the allegation included statements from staff who were present at the time. A statement documented from CNA # 2 indicated " Sitting at nurses station he said needed Teds off, CNA # 2 asked to take off, (Resident # 104 name) said 'no', RN # 1 said she had to have them off b/c		interviews of residents on the unit where RN #1 worked. RN #1 was placed on suspension and an investigation was initiated. Results of the investigation were found to be identical to those brought up in the Resident Council Meeting that day. RN #1 was terminated on 6/16/11. All staff are educated on Resident Rights and Abuse Prohibition twice a year. All Staff will be re-inserviced on Abuse Prohibition, Reporting, and Investigation (Attachment “A” - 3 pages) To monitor for ongoing compliance with this corrective action, the Administrator and/or designee will be responsible for completing the QA tool Titled “Resident Satisfaction Survey” (Attachment “B”- 3 pages). This QA tool will be completed monthly indefinitely. Reviews and changes will be completed by July 17, 2011	

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	(because) Dr. (Doctor) said, he didn't care what she said, he pulled shoe off and peeled Ted hose off, she screamed "Don't touch me." She crossed legs he uncrossed her legs and took other shoe and Ted hose off. She said "Don't hurt me" LPN # 3 then came b/c of yelling. CNA # 2 went to get socks, then LPN # 3 said he cussed at Resident # 104 about 1 a.m. Resident # 104 won't stay in bed at night." A statement documented by LPN # 3 dated 10/31/10 indicated " I went to get 02 supplies on SNF (skilled nursing facility). Heard RN #1 yelling at Resident # 104 "You are not wearing your G.. d... Ted hose to bed, I don't care what you want, you are going to bed now." Resident was crying "give me my socks, don't hurt me, don't hurt me please." I went to resident and redirected her to her room, assisted her to bed. RN # 1 threw Teds at me when I asked for them. Resident was tearful and did not want this writer to leave room. CNA # 2 stayed with Resident awhile longer." Another statement addressed to the DON, documented and signed by both LPN # 3 and CNA # 2 dated 10/31/10 indicated " I am concerned about the way RN # 1 is talking to and treating the residents tonight. Resident # 104 was sitting at the desk with us and he wanted me to take her			

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	Teds off and she wouldn't let me so he grabbed her leg and started pulling at the hose. She was yelling at him to stop and leave her alone and he jerked her other leg up and ripped the hose off. LPN # 3 was walking by and heard what was going on and she stepped in because Resident # 104 was crying and scared, yelling "please don't hurt me." Then LPN # 3 and I got her up and took her to her room and calmed her down and got her in bed. LPN # 3 called LPN # 4 and is waiting for her to call back...." 2. During the Resident Group meeting interview on 6/15/11 at 10:00 A.M., Resident #29 indicated she would like to sleep in until 6:30 A.M., but one particular night nurse makes her get up at 5:30 A.M. even though she dresses herself and does not need to be down for therapy until 9:00 A.M. Resident #29 indicated in an interview on 6/15/11 at 3:30 P.M., RN #1 would come to her room and insist that she get up at 5:30 A.M. even though she requested to sleep at least another hour longer. She indicated RN #1 would return and stand in her doorway and glare at her if she was not up and dressed when he returned to check on her. "He insists that I get up at 5:30 A.M. He's like a drill sergeant in the military! I stopped using my call light			

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	during the night because I don't want him to respond to it. I make sure I use the bathroom before the end of the second shift so I don't have to use it during the night so as to avoid him. When Resident #29 was queried if she was afraid of RN #1, she indicated she felt there were enough people in the building that he would not hurt her, but she definitely felt intimidated by him. During initial tour of the facility on 6/13/11 at 12:45 P.M., RN #5 indicated Resident #29 was alert, oriented, and interviewable. Review of Resident #29's initial MDS (Minimum Data Set) Assessment on 6/17/11 at 2:00 p.m., dated 6/02/11, indicated she was cognitively intact. 3. During initial tour of the facility on 6/13/11 at 12:45 P.M., RN #5 indicated Resident #27 was alert, oriented, and interviewable. Resident #27 indicated in an interview on 6/15/11 at 4:00 P.M., RN #1 comes into her room in the middle of the night and flips on her overhead lights. He startles me when he does it because he does not knock on the door and I'm not expecting it. He takes me into the bathroom and undresses me and watches			

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	me take a BM (bowel movement) and wipe myself while I'm sitting there 'stark nude.' I even complained to my doctor about it because it makes me feel funny." 4. During initial tour of the facility on 6/13/11 at 12:45 P.M., RN #5 identified Resident #25 as alert, oriented, and interviewable. Resident #25 stated in an interview on 6/17/11 at 1:50 P.M., "I was afraid of him (RN #1). He made me nervous." He indicated he was uncomfortable the eight hours RN #1 was on duty and was afraid to ask for anything. "I would wait until he left and then get what I needed." During interview with the Administrator on 6/16/11 at 10:00 A.M., she indicated she interviewed Resident #25 and he had indicated he wanted to wear pull-up incontinence briefs, but RN #1 insisted he wear the brief that taped together on the sides. She indicated he did as he was told by RN #1, but then changed into the pull-up brief later. 3.1-3(a)(1)			

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F0223 SS=E	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from intimidation and mental anguish for 1 of 1 residents reviewed for abuse in a sample of 20 and 3 of 3 in a supplemental sample of 3. Residents: # 29, #104, # 27 and # 25 Findings include: 1. Resident # 104's closed record was reviewed on 6/17/11 at 9:30 a.m. The Resident's record indicated diagnoses of, but not limited to; history of falls, Alzheimer's disease, and inability to ambulate. The Resident's record indicated she was admitted on 9/23/10. Review of the Resident's 5 day MDS (Minimum Data Set) assessment dated 10/1/10 indicated "cognition; modified independence- some difficulty in new situations only. Moods were present but	F0223	**F223 Free From Abuse/ Involuntary Seclusion** It is the policy of Miller's Merry Manor – Plymouth that each resident has the right to be free form verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This deficient practice has the potential to affect all residents where RN #1 was working. Resident #104 is discharged from the facility. Residents #29, #27, and #25 were interviewed on 6/16/2011 and felt confident in remaining in the facility. They were all assured that their individual rights will be respected. On 6/15/11, after being informed of the findings during resident council the Administrator, DON, and Social Service Director conducted interviews of residents on the unit where RN #1 worked. RN #1 was placed on suspension and an investigation was initiated. Results of the investigation were found to be identical to those brought up in the Resident Council Meeting that day.	07/17/2011

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	easily altered." She needed extensive assistance with transfers, and dressing. A physician's order dated 10/4/10 indicated "Knee high Ted (thrombo embolic deterrent) hose on in a.m. off at p.m." Review of an incident reported on 10/31/10 indicated the following; "The Director of Nursing was called and notified that during the midnight shift, a staff person was overheard speaking loudly to a resident and then removed her Ted hose despite her stating she wished to continue to wear them." The facility's investigation regarding the allegation included statements from staff who were present at the time. A statement documented from CNA # 2 indicated " Sitting at nurses station he said needed Teds off, CNA # 2 asked to take off, (Resident # 104 name) said 'no', RN # 1 said she had to have them off b/c (because) Dr. (Doctor) said, he didn't care what she said, he pulled shoe off and peeled Ted hose off, she screamed "Don't touch me." She crossed legs he uncrossed her legs and took other shoe and Ted hose off. She said "Don't hurt me" LPN # 3 then came b/c of yelling. CNA # 2 went to get socks, then LPN # 3 said he cussed at Resident # 104 about 1 a.m. Resident #		RN #1 was terminated on 6/16/11. All staff are educated on Resident Rights and Abuse Prohibition twice a year. All Staff will be re-inserviced on Abuse Prohibition, Reporting, and Investigation (Attachment “A” -3 pages) To monitor for ongoing compliance with this corrective action, the Administrator and/or designee will be responsible for completing the QA tool Titled “Resident Satisfaction Survey” (Attachment “B” -3 pages). This QA tool will be completed monthly indefinately. Reviews and changes will be completed by July 17, 2011	

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	104 won't stay in bed at night." A statement documented by LPN # 3 dated 10/31/10 indicated " I went to get 02 supplies on SNF (skilled nursing facility). Heard RN #1 yelling at Resident # 104 "You are not wearing your G.. d... Ted hose to bed, I don't care what you want, you are going to bed now." Resident was crying "give me my socks, don't hurt me, don't hurt me please." I went to resident and redirected her to her room, assisted her to bed. RN # 1 threw Teds at me when I asked for them. Resident was tearful and did not want this writer to leave room. CNA # 2 stayed with Resident awhile longer." Another statement addressed to the DON, documented and signed by both LPN # 3 and CNA # 2 dated 10/31/10 indicated " I am concerned about the way RN # 1 is talking to and treating the residents tonight. Resident # 104 was sitting at the desk with us and he wanted me to take her Teds off and she wouldn't let me so he grabbed her leg and started pulling at the hose. She was yelling at him to stop and leave her alone and he jerked her other leg up and ripped the hose off. LPN # 3 was walking by and heard what was going on and she stepped in because Resident # 104 was crying and scared, yelling "please don't hurt me." Then LPN # 3 and I got			

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her up and took her to her room and calmed her down and got her in bed. LPN # 3 called LPN # 4 and is waiting for her to call back...."

During an interview with the Administrator on 6/16/10 at 11:00 a.m. regarding the above allegation of abuse, she indicated she was on leave at that time and an interim administrator was in charge. She indicated the Director of Nursing was notified and had came in and suspended RN # 1. She indicated because of some conflict in the interviews, the allegation was unsubstantiated.

The investigation indicated RN # 1 was inserviced on Resident Rights, Abuse and Neglect and Customer Service on 11/5/10 prior to returning to employment.

In reading the interviews from the staff present during the night shift with RN # 1, a conflict in the story is not apparent. Both staff (CNA #2 and LPN # 3) both substantiated the abusive behavior of RN #1 to Resident # 104.

A documented statement from RN # 1 dated 11/5/10, indicated " ...I apologize for any miss conduct on my behalf, I was just concerned about the resident's condition and was trying to help her. I did not mean for any wrong doing on my part

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	or to miss represent this fine facility." A follow-up letter to ISDH dated 11/4/10 indicated "...A full investigation was completed. A head to toe assessment was completed with no injuries noted. An interview was completed with (Resident # 104) in which she was unable to recall the incident. Resident # 104 denies pain or discomfort and exhibits no ill effects related to the incident. Statements from staff on duty were reviewed. Other residents on that unit were interviewed by the Social Service Director with no further findings. Allegations against RN #1 are unsubstantiated...." The investigation conducted on 11/1/10 by Social Service staff # 6 only included interviews from three other residents. None of the three residents interviewed complained about RN # 1. 2. During the Resident Group meeting with State surveyors on 6//15/11 at 10:00 A.M., Resident #29 indicated she would like to sleep in until 6:30 A.M., but one particular night nurse makes her get up at 5:30 A.M. even though she dresses herself and does not need to be down for therapy until 9:00 A.M.			

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Resident #29 indicated in an interview on 6/15/11 at 3:30 P.M., RN #1 would come to her room and insist that she get up at 5:30 A.M. even though she requested to sleep at least another hour longer. She indicated RN #1 would return and stand in her doorway and glare at her if she was not up and dressed when he returned to check on her. "He insists that I get up at 5:30 A.M. He's like a drill sergeant in the military! I stopped using my call light during the night because I don't want him to respond to it. I make sure I use the bathroom before the end of the second shift so I don't have to use it during the night so as to avoid him. When Resident #29 was queried if she was afraid of RN #1, she indicated she felt there were enough people in the building that he would not hurt her, but she definitely felt intimidated by him.

During initial tour of the facility on 6/13/11 at 12:45 P.M., RN #5 indicated Resident #29 was alert, oriented, and interviewable.

Review of Resident #29's initial MDS (Minimum Data Set) Assessment, dated 6/02/11, indicated she was cognitively intact.

3. During initial tour of the facility on

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	6/13/11 at 12:45 P.M., RN #5 indicated Resident #27 was alert, oriented, and interviewable. Resident #27 indicated in an interview on 6/15/11 at 4:00 P.M., RN #1 comes into her room in the middle of the night and flips on her overhead lights. He startles me when he does it because he does not knock on the door and I'm not expecting it. He takes me into the bathroom and undresses me and watches me take a BM (bowel movement) and wipe myself while I'm sitting there 'stark nude.' I even complained to my doctor about it because it makes me feel funny." 4. During initial tour of the facility on 6/13/11 at 12:45 P.M., RN #5 identified Resident #25 as alert, oriented, and interviewable. Resident #25 stated in an interview on 6/17/11 at 1:50 P.M., "I was afraid of him (RN #1). He made me nervous." He indicated he was uncomfortable the eight hours RN #1 was on duty and was afraid to ask for anything. "I would wait until he left and then get what I needed." During interview with the Administrator on 6/16/11 at 10:00 A.M., she indicated she interviewed the above mentioned residents and they all confirmed they had			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bad experiences with RN #1. Resident #25 had indicated he wanted to wear pull-up incontinence briefs, but RN #1 insisted he wear the brief that taped together on the sides and he did as he was told by RN #1, but then changed into the pull-up brief later. She further indicated RN #1 would no longer be employed by the facility and was terminated on 6/16/11. A facility policy titled "Abuse Prohibition, Reporting, and Investigation," dated 6/13/11, indicated, 1. Policy: It is the policy of Miller's Health Systems that all residents have the right to be free from verbal, sexual, physical and mental abuse...2. Definitions: Abuse-Physical, sexual, verbal and/or mental (known or alleged) abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...D. Mental Abuse-includes, but not limited to, humiliation, harassment, and threats of punishment...." 3.1-27(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING 00 B. WING	06/17/2011

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders and plan of care were followed related to blood sugars and administration of insulin coverage for 1 of 4 residents (Resident # 41) reviewed for diabetes in a sample of 20. Findings include: 1. The clinical record for Resident # 41, reviewed on 6/14/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, Crohn's disease, peri-rectal fistula, and obesity. A Physician Order, dated 3/30/11, indicated, "...Check BS (Blood Sugar) 6 A.M., 11 A.M., 4 P.M., and 9 P.M....Regular Insulin per sliding scale: 151-200 = 3 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units..." Review of the April 2011, MAR (Medication Administration Record), indicated incorrect sliding scale coverage for the following Accu Check (blood sugar test) result:	F0282	**F282 Services By Qualified Persons/Per Care Plan** It is the policy of Miller's Merry Manor of Plymouth to administer insulin coverage as ordered and document findings on the appropriate Blood Glucose Monitoring Form. This deficient practice has the potential to affect all residents receiving insulin coverage. Resident #41 has had insulin coverage orders reviewed, suffered no negative effects from insulin dosage administered. Resident #41 continues to be a resident in this facility and is receiving care per physician plan of care and orders. All nurses were re-educated on the facility policy regarding Blood Glucose Monitoring (Attachment "C" - 2 pages) on June 22, 2011. An in-service will be done with all nurses on reading and administering sliding scale insulin. This will include return demonstration. To monitor for ongoing compliance with this corrective action, the DON and/or designee will review all orders for residents receiving sliding scale insulin to ensure accuracy. The DON and/or designee will also complete the QA audit tool labeled "Blood Glucose Monitoring and Following MD sliding scale orders" (Attachment "D" - 1 page). This	07/17/2011

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	4/18/11 at 11:00 A.M., Accu Check result 255. The clinical record indicated the Resident received 6 units but should have received 8 units. The next available BS (blood sugar) on 4/18/11 at 4:00 P.M., was 287. Review of the May 2011, MAR (Medication Administration Record), indicated incorrect sliding scale coverage for the following Accu Check (blood sugar test) result: 5/11/11 at 4:00 P.M., Accu Check result 370. The clinical record indicated the Resident received 10 units but should have received 12 units. The next available BS (blood sugar) at 9:00 P.M. was 240. 5/12/11 at 4:00 P.M., Accu Check result 290. The clinical record indicated the Resident received 6 units but should have received 8 units. The next available BS at 9:00 P.M. was 268. 5/19/11 at 9:00 P.M., Accu Check result 367. The clinical record indicated the Resident received 8 units but should have received 12 units. The next available BS at 6:00 A.M. on 5/20/11, was 268. 5/22/11 at 11:00 A.M., Accu Check result		audit tool will be done weekly for four weeks and monthly thereafter. Reviews and changes will be completed by July 17, 2011.	

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	205. The clinical record indicated the Resident received 3 units but should have received 6 units. The next available BS at 4:00 P.M. was 306. Resident # 41's Care Plan, dated 4/4/11, indicated, "...Give insulin as ordered..." During interview with RN # 5 on 6/17/11 at 9:00 A.M., she indicated the incorrect amount of sliding scale coverage was given for the above five occasions. She further indicated the MAR's are checked at the end of the month for completeness but not accuracy. A facility policy titled, "Blood Glucose Monitoring", dated 7/1/2009, indicated, "...Administer insulin coverage as ordered...Document findings on the appropriate Blood Glucose Monitoring form...." 3.1-35(g)(2)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer which resulted in the development of an unstageable pressure sore before the area was identified by staff for 1 of 2 residents (Resident # 12) reviewed for pressure ulcers in a sample of 20. Findings include: 1. The clinical record for Resident # 12 reviewed on 6/14/11 at 9:40 A.M., indicated diagnoses of, but not limited to: decubitus ulcer left foot, multiple sclerosis, dementia, and neurogenic bladder.	F0314	**F314 Treatment Services to Prevent Heal/Pressure Sores**This tag is currently in disputeIt is the policy of Miller's Merry Manor of Plymouth to prevent the development of pressure ulcers.Resident #12's pressure ulcer was incorrectly staged as unstageable initially upon discovery and should have been staged at Stage II- partial thickness wound, blister/fluid filled deflated intact area. It presented without slough or eschar. The area which is now staged at a Stage II is healing and treatment continues without complications.All residents residing in the facility have the potential to develop pressure ulcers.Residents receive a complete head to toes assessment at a minimum weekly	07/17/2011

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	During initial tour on 6/13/11 at 11:05 A.M., accompanied by RN # 7, she indicated Resident # 12 had a unstageable open area on the outside portion of the left foot. Review of a "MDS" (Minimum Data Set), dated 4/7/11, indicated, "...Bed mobility...3 (limited assistance)...3 (Two + persons physical assist)...Transfer...4 (Total dependence)...3 (Two + persons physical assist)...Functional Limitation in Range of Motion...Upper extremity...2 (Impairment on both sides)...Lower extremity...2..." A "Nursing-Braden Scale", dated 4/7/11, indicated, "...Sensory Perception...Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities....Moisture...Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals....Activity...Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair....Mobility...Completely Immobile: does not make even slight changes in body or extremity position without		by the licensed nurse(s). Any new skin areas found are immediately assessed, physician is notified as well as responsible party, and appropriate treatment is initiated. If the skin area is identified as a pressure area, the aforementioned applies and further notification is given to the assigned Wound Nurse, who will either make a new assessment at that time or concur with the initial assessment. At a minimum thereafter until the area is healed, the pressure area will be assessed weekly and documentation, not limited to but including status/stage will be done at that time. Additionally as warranted per facility policy, the pressure area will be assessed and monitored/treated by the facility contracted Wound Physician Specialist.Weekly, all pressure areas and the status thereof, are reviewed during the quality of life meeting by the assigned wound nurse, MDS coordinator, FSS, DON and or designee to review status and appropriate treatment and care. Therapy staff will be re-inserviced with the facility splint representative on the types of splints, when they should be used, and possible side affects. Therapy will also be re-inserviced on splint utilization, assessing, documentation, and communication to nursing staff on any skin issues noticed under their care.It has also be	

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	assistance...Nutrition...Adequate...Friction & Shear...Potential Problem: Moves feebly or requires minimum assistance..." Review of the PT (Physical Therapy) Treatment Notes indicated, "...4/12/11...Bilateral ankle/foot orthotic device required to accommodate ROM (range of motion) limitations....4/13/11...Pt (patient) tolerated one hour of application with blanchable erythema on balls of feet....4/14/11...Pt tolerated two hours of application...4/15/11...Pt tolerated one hour of application...4/20/11...Restorative staff training of orthotic application, care, wearing schedule and precautions of splint/orthotic device....4/21/11...Educated restorative staff for proper application of bilateral ankle orthosis....4/25/11 Tolerated 2 hours this date....4/27/11 Instruction in orthotic application, schedule, wearing precautions and orthotic care....5/4/11...Skin assessment on plantar aspect of feet (ball of feet) including skin integrity. Pt tolerated wearing bilateral foot splints during lunch time with blanchable redness....5/6/11 Pt tolerated wearing bilateral foot splints during lunch time...5/9/11 CNA (Certified Nursing Assistant) (Name) staff training of bilateral foot orthotic application, wearing schedule and precautions of splint/orthotic device....5/11/11...DC		determined that therapy will not discharge a patient to a restorative nursing program until the resident has met and sustained all goals for a period of one week.To further prevent recurrence of this finding, any resident's who currently utilize splinting devices will have complete skin assessments done by 7/8/2011. The application and removal/care of splints is being completed by and documented by assigned licensed nurses each shift. The audit tool entitled “Pressure Ulcer Risk Reduction & Treatment Review” (Attachment “E” - 2 pages) will continue to be done monthly by the DON/ADON/MDS coordinator or designee. Findings will be reviewed at the monthly QA meeting for correction or change in plan of care.Reviews and changes will be completed by July 17, 2011.	

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	(discontinue) services..." A Physician Order, dated 4/27/11, indicated, "...Pt to wear bil (bilateral) foot splints for 2 hours when up in W/C (wheelchair) for meals at 7 A.M. - 9 A.M., 11 A.M. - 1 P.M., 4 P.M. - 6 P.M....monitor skin bottom feet for red or irritated areas..." Review of a Progress Note, dated 6/7/11, indicated, "...resident noted to have area to left lateral foot upon removal of foot splints...." A "Wound Assessment", dated 6/7/11, indicated, "...Date originally noted: 6/7/11...Type of wound: Pressure-Unstageable...left lateral foot...Length 1.5 (cm-centimeters)...Width 1.0...Wound...intact...Wound Bed...dry, intact, unable to assess under thick adherent tissue...Necrosis...unable to assess...Surrounding Skin...pink and intact...new splint of foot from therapy...decreased cognition, decreased mobility... Physician Order, dated 6/7/11, indicated, "...discontinue bilateral foot/ankle splints-causing areas of concern to feet..." A "Wound Assessment", dated 6/15/11, indicated, "...Pressure-Unstageable...left			

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	lateral foot...Length 0.8... Width 1.5... A Care Plan, initiated on 4/12/10, revised on 5/22/11, indicated, "...Potential for skin breakdown...Monitor skin daily during care.... Review of a Care Plan, revised on 6/7/11, indicated, "...Actual skin breakdown related to: pressure, left lateral foot...Goals...Show reduction in size/stage of pressure ulcer..." During observation of Resident # 12's left lateral pressure ulcer on 6/16/11 at 2:20 P.M., LPN # 16 uncovered Resident # 12's feet and socks. The left lateral foot wound appeared the size of a dime with a dark black center (eschar). During interview with Therapy Assistant # 17 on 6/17/11 at 12:40 P.M., she indicated Resident # 12's splints were first applied in therapy on 4/12/11, discharged from therapy on 5/11/11 and nursing took over application of splints on 5/12/11 and were responsible for splint application from that point forward.. Interview with Physical Therapist # 18 on 6/17/11 at 1:35 P.M., she indicated Resident # 12's pressure sore was probably caused by the braces.			

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	3.1-40(a)(1)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure hair was properly restrained and staff properly washed their hands prior to handling residents food and utensils. This deficient practice had the potential to affect all 100 residents who dine in the facility. Findings include: 1. During observation of the facility kitchen on 6/13/11 at 11:55 A.M., the following was observed: Dietary Aide #9 rubbed her face three times, one time	F0371	**F371 Food Procure, Store/Prepare/Serve – Sanitary** It is the policy of Miller's Merry Manor of Plymouth to follow sanitation and hand washing policy. This deficient practice has the potential to affect all residents who dine in the facility. The dietary staff were re-inserviced on the facility Handwashing Policy (Attachment "F" - 2 pages) and Personal Hygiene policy (Attachment "G"- 1 page) and the proper use of hair nets. Contractor #14 was educated on facility policy of hair net. He is not a regular vendor to our faciltiy. The facility has also placed a sign in at	07/17/2011

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	using her thumb nail to scratch her cheek below her right eye, and then proceeded to make a broth for a resident's meal without washing her hands. Cook #10 was observed preparing beverages and covering them with a plastic wrap after he was observed in the soiled dish area of the kitchen. He did not wash his hands between the tasks of handling soiled dishes and preparing the beverage glasses. Cook #12 was observed scratching her face with her bare hands and then assisted with food trays. She did not wash her hands prior to handling food items. Cook #11 was observed tucking her hair into her hair net while standing at the steam table just prior to serving the food. She was then observed touching residents plates and bowls to serve up their food without first washing her hands. Cook #13 was observed removing the lid off of a trash can and then proceeded to top the butterscotch pudding with whipped cream. She did not wash her hands between the tasks. During interview with Dietary Manager on 6/13/11 at 12:10 P.M., she indicated staff had recently been inserviced on handwashing and sanitation. 2. Contractor #14 was observed at the steam table in the facility kitchen on 6/13/11 at 12:15 P.M. The steam table		the entrance of kitchen doors stating "All Staff, Visitors, Vendors must wear a hair net when entering the kitchen". (Attachment "H" - 1 page) The Dietary Manager and or designee will complete the QA audit tool labeled "Personal Hygiene and Handwashing"(Attachment "I" - 2 pages). This will be completed every day for two weeks, weekly for 4 weeks and monthly thereafter. All reviews and changes will be made by July 17, 2011.	

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	had prepared food on it that was being served onto residents plates at the time. He was not wearing a hairnet or cap over his hair. During interview with Contractor #14, at the time, he indicated he was unaware that he needed to wear something over his hair prior to entering the kitchen. 3.1-21(l)(3)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure the clinical record was accurate and complete for 1 of 4 residents (Resident # 41) reviewed for diabetes in a sample of 20. Findings include: 1. The clinical record for Resident # 41,	F0514	**F514** **Records-Complete/Accurate/Accessible** It is the policy of Miller's Merry Manor of Plymouth to administer insulin coverage as ordered and document findings on the appropriate Blood Glucose Monitoring Form. This deficient practice has the potential to affect all residents receiving insulin coverage.	07/17/2011

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	reviewed on 6/14/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, Crohn's disease, peri-rectal fistula, and obesity. A Physician Order, dated 3/30/11, indicated, "...Check BS (blood sugar)6 A.M., 11 A.M., 4 P.M. and 9 P.M.,...Regular Insulin per sliding scale: 151-200 = 3 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units..." Review of the April 2011, MAR (Medication Administration Record), lacked documentation of coverage given for the following Accu Check results: 4/1/11 at 6:00 A.M., 4:00 P.M., 9:00 P.M. 4/2/11 at 9:00 P.M. The clinical record lacked documentation of the amount of sliding scale coverage given for the above four Accu Check's. Resident # 41's Care Plan, dated 4/4/11, indicated, "...Give insulin as ordered..." During interview with RN # 5 on 6/17/11 at 9:00 A.M., she indicated the MAR lacked documentation of the amount of sliding scale coverage given. She further indicated the MAR's are checked at the end of the month for completeness but not		Resident #41 has had insulin coverage orders reviewed, suffered no negative effects from insulin dosage administered. Resident #41 continues to be a resident in this facility and is receiving care per physician plan of care and orders. All nurses were re-educated on the facility policy regarding Blood Glucose Monitoring (Attachment "C") on June 22, 2011. An in-service will be done with all nurses on reading and administering sliding scale insulin. This will include return demonstration. To monitor for ongoing compliance with this corrective action, the DON and/or designee will review all orders for residents receiving sliding scale insulin to ensure accuracy. The DON and/or designee will also complete the QA audit tool labeled "Blood Glucose Monitoring and Following MD sliding scale orders" (Attachment "D"). This audit tool will be done weekly for four weeks and monthly thereafter. Reviews and changes will be completed by July 17, 2011.	

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	accuracy. A facility policy titled, "Blood Glucose Monitoring", dated 7/1/2009, indicated, "...Administer insulin coverage as ordered...Document findings on the appropriate Blood Glucose Monitoring form...." 3.1-50(a)(1)			